Department of Health and Mental Hygiene
Developmental Disabilities Administration
Fee Payment System Invoice

DAY/RESIDENTIAL **(circle one)** _____**QTR - FY** _____

Invoice for Period *From:* _____ *To:* _____

Provider Name _____ *Provider #* _____

*Federal I.D. #*_____

*Address:*_____

*Name of Contact Person:*_____

*Telephone Number:*_____

Provider=s Billing Rate **$** _____

Number of Billable Days **X** _____

Amount Due Provider **$** _____

Plus: *Special Cost Center* _____

Less: *Advance Payment* _____

Other Adjustments, If any _____

Net Amount Due Provider _____

ATTESTATION

I certify by my signature that this request/invoice is for service provided and does not represent any claims previously billed or received.

_____
Name ***Title***

_____
Signature ***Date***

****

FOR DHMH USE ONLY

32.13.01 **Grant Number:** _____

APPROVED FOR PAYMENT

_____
Signature ***Title*** ***Date***

A**EXEMPT from Procurement under COMAR 21.01.03.01A**@

DHMH 4356